PATIENT INFORMATION DATE_____

PATIENT NAME_____DATE OF BIRTH_____

STREET_____CITY_____ST_____ZIP_____

SEX_____MARITAL STATUS_____SS#_____EMPLOYER_____

HOME PHONE_____WORK PHONE_____CELL_____

EMAIL_____REFERRED BY_____

FINANCIAL RESPONSIBILITY

NAME_____RELATIONSHIP TO PATIENT_____

STREET_____CITY_____ST_____ZIP_____

HOME PHONE_____WORK PHONE_____CELL_____

INSURANCE INFORMATION

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

INSURED'S D.O.B._____EMPLOYER_____PHONE_____

NAME OF INSURANCE CARRIER_____PHONE _____

ADDRESS_____CITY_____ST_____ZIP_____

SS# OF INSURED_____POLICY ID#_____GROUP #_____

IF SECONDARY INSURANCE IS AVAILABLE, PLEASE COMPLETE BELOW

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

INSURED'S D.O.B._____EMPLOYER_____PHONE_____

NAME OF INSURANCE CARRIER_____PHONE _____

ADDRESS_____CITY_____ST_____ZIP_____

SS# OF INSURED_____POLICY ID#_____GROUP #_____

RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process this claim:

Signature of patient or parent/guardian_____Date_____

I authorize payment of medical benefits directly to the provider:

Signature of patient or parent/guardian_____Date_____

FOR OFFICE USE ONLY

THERAPIST:_____DIAGNOSIS CODE 1:_____2:_____